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Relationship Between Attachment and Out-of-Home Placements in Emotionally and Behaviorally Disordered Male Adolescents

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RELATIONSHIP BETWEEN ATTACHMENT AND OUT-OF-HOME PLACEMENTS
IN EMOTIONALLY AND BEHAVIORALLY DISORDERED MALE ADOLESCENTS

BY

GAIL M. CURRAN

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Abstract

Since its inception, Bowlby's attachment theory has guided research in the area of attachment. A body of literature supports the conclusion that when attachment needs are not met in the first year of life, serious deficits and problems can occur. The present study adds to the existing literature by examining attachment in adolescents, an age group not frequently researched. Specifically, this study examines the relationship between attachment and multiple out-of-home placements for adolescent males living in a residential treatment facility.

In order to understand the characteristics of youth living in a residential treatment facility, an archival search was completed to build a profile on the characteristics of male adolescents living in a residential treatment facility. The youth are in treatment for behavior and emotional disorders. The youth's attachment was measured using the Randolph Attachment Disorder Questionnaire (RADQ).

A significant difference was found in the number of out-of-home placements in youth scoring in the severe versus mild or no attachment categories. Another interesting finding was the lack of a difference in the RADQ ratings produced by male and female raters, as the RADQ author had suggested. Although other analyses were conducted, the small sample size (N=28) limits the utility of more sophisticated analyses.

Findings are related to previous research and are highlighted in terms of their possible contributions to developing treatment and interventions for improving the likelihood of later success. Limitations of the study and future research are also discussed.

Acknowledgments

I would like to mention the many people who have made the completion of this project possible. First, I would like to thank my major Professor, Diane Horm-Wingerd, for telling me to “follow my heart”. Her assistance in making this study an extension of my interest in attachment is greatly appreciated and helped, especially in the end, maintain the projects momentum and my inspiration.

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I want to thank Harmony Hill School, Inc for allowing me to conduct my research, especially to Terry Leary, who if it were not for him, this project would not have been possible. I also have to thank the child care workers and especially the children whom I love so much. The State of Connecticut was invaluable to my research. Their professionalism and true desire to find better ways of treating a difficult population was evident.

Finally, I would like to thank my husband and son who supported me and was patient when I was spending most of my free time working on this project. Thank-you for being there for me.

Preface

This manuscript was prepared under the guidelines of the American Psychological Association (APA) (1994) and the University of Rhode Island Thesis and Dissertation Format Guidelines.

I became interested in this topic through my 15 years of experience working in the field of childcare and treatment with emotionally and behaviorally disordered children living in residential treatment centers.

This project to study the characteristic of youth's living in a residential treatment facility and the relationship between number of out-of-home placements and level of attachment disorder was done in conjunction with the residential treatment center, in which I was employed, the Department of Children and Families for the State that gave consent, and to the consenting parents and children. The information obtained from this research will hopefully be used to further investigate the issue of attachment in children and families. In addition to contributing to the study of attachment in children with emotional and behavioral problems, it is my hope to extend this research to a larger population to gain knowledge in the treatment of attachment disorders in children.

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Introduction

Attachment is all about protection. As a whole, our society is failing to protect our children. With child abuse and neglect on the rise and institutions filled to capacity, experts suggest that we need to take a closer look at the issue of attachment (Main, Kaplan, & Cassidy, 1989.).

Attachment Theory

Bowlby (1982a) derived his conceptualization of attachment and attachment behavior from ethnological studies of animal behavior. He suggested that certain systems were instinctual and contributed to the survival of the individual and species. The attachment system maintained its biological functions throughout the life cycle, although behaviors fulfilling those functions change as the organism matures (Rice, 1990). Bowlby argued that a child's tie to his or her mother was the result of several behavioral systems that have proximity to mother as a predictable outcome. Motivation is implicit in the attachment system (Ainsworth, 1969).

Attachment denotes an inclination to seek proximity. It is a strong affectionate bond between individuals. An attachment is enduring and independent of situational circumstances or environmental contingencies (Bowlby, 1969).

Attachment behavior is elicited by stressful situations in which proximity to a caretaker becomes important. A stressful situation is one that signifies a threat to the survival of the organism. The closeness that attachment behavior has as its goal can be

overtly physical (i.e. clinging) or psychological, and generally enables one to feel safe and secure.

Although very little is known about the possible risk factors in infancy and the development of later psychopathology, the influence of early infant-caregiver relationships on later development has received empirical support. Eicker, Englund, and Strouffe (1992) for example, found that infant attachment classification patterns were reliably associated with self-confidence and social skills at ten years of age. Evidence exists that the attachment pattern an infant exhibits seems to have consequences for future relationships, and these consequences are thought to be the result of the internal working models forged during infancy via parent-child interactions (Benoit & Parker, 1994). Other studies have found that security/insecurity of attachment in infancy is able to reliably predict a wide range of phenomena during the preschool and elementary years, including school adjustment, behavioral problems, quality of peer relationships and non-parental adults, and quality of familial relationships (Lewis, Feiring, McGuff, & Jaskir, 1984, Kenderville and Main, 1981, Erickson, Stroufe, Egeland, & Kreutzer, 1990). In essence, attachment theorists maintain that the infant's first attachment relationship is of paramount importance in the genesis of social-emotional development and psychopathology (Bowlby, 1969, 1973). Additionally, a series of studies linking the quality of infants' early attachment relationship to the quality of later social – emotional functioning provides evidence of continuity in individual social-emotional development through infancy, toddlerhood, and the preschool period (Arend, Gove & Stroufe, 1979; Londerville & Main, 1981; Main, 1977; Matas, 1978; Paster, 1981; Waters, 1979).

According to attachment theory, children's failure to develop a positive attachment is associated with a number of symptoms (Curtis, 1985). All or some of the following symptoms can be present: (1) lack of ability to give and receive affection; (2) superficial attractiveness and friendliness to strangers; (3) preoccupation with blood, gore, and fire; (4) cruelty to others, especially animals; (5) abnormalities in eye contact; (6) abnormalities in speech patterns; (7) lying when it doesn't make sense to lie or there is no reason to lie; (8) stealing, hoarding or gorging; (9) lack of long-term friends; and, (10) extreme control problems. According to Curtis, these symptoms occur in varying degrees of intensity, depending on the severity of the circumstances that led to the disruption of the attachment. In the 1940's, John Bowlby (1944) hypothesized that the aggressive delinquent behaviors seen in children who had experienced prolonged and multiple separations from their primary caretakers were the result of disrupted attachment.

Attachment disorders have been in the literature for many years, but the label, as a diagnosis, is relatively new. Residential treatment centers are overflowing with children who fit this diagnostic category, but few are officially diagnosed as having Reactive Attachment disorder as outlined in the DMS-V (Randolph, 1997). Many of the behaviors that require a great deal of time and energy by caregivers emerge from attachment issues. There is a proportion of children in institutional settings who engage in extreme acting out behavior, which may be related to one of the consequences of attachment disorder. For most children in residential programs, impulsive and acting out (aggressive) behaviors arises from multiple ego deficits (Small, 1991). This is the result of pervasive trauma, lack of adequate attachments, or lack of support and direction during crucial

developmental phases. Histories of failures in school and in social relationships may also occur (Small, 1991).

Pervasive failure in socialization lessens the likelihood of these children joining or empathizing with others. Cashden, Barker and others (1980) delineated the same picture in terms of attachment disorders resulting from discontinuities in early relationships with caretakers and exacerbated by multiple placements often characteristic of children in multiple out-of-home placements. Most children in residential treatment have extreme difficulty in making and maintaining basic human connections. This is largely due to not having strong attachment figures early in their life (Small, 1991).

In addition to residential facilities, foster home programs find that these unattached children cannot be cared for with average or even above average parenting skills. These children cannot change by giving them a little more attention and love (Magid, 1989). Often, unattached children are bounced from foster home to foster home and to other out-of-home placements, such as residential treatment centers and psychiatric hospitals. This gives them virtually no chance of building any type of relationship. Unattached children have been known to be placed in up to 19 placements (Ragfield, 1990).

Children who suffer from attachment disorders often present a variety of possible diagnoses. Their behavior often appears similar to (and may be often misdiagnosed as) conduct disorder, attention deficit hyperactivity disorder, bipolar disorder, and personality disorder, all of which can create a confusing and complicated clinical picture (Randolph, 1997).

Because little is known about youth who experience multiple out-of-home placements, a purpose of the present study was to examine basic demographic characteristics such as age at first out-of-home placement, diagnoses, IQ, ethnic origin, number of placements and record of criminal behavior for a group of boys who have experienced multiple out-of-home placements. The second, and primary purpose of this study, was to examine the relationship of attachment status and multiple out-of-home living placements, such as foster care, psychiatric hospitalization, and residential treatment centers. The research question was: Is the attachment status of children related to multiple out-of-home placements? Specifically, it was predicted that the number of placements would be significantly related to the severity of attachment disorder.

Method

Participants:

Recruitment of subjects to participate in this study was done over a six-month period. There were 28 boys involved in this study. The sample came from a population of 56 male adolescents, between the ages of 11 and 17, living in a residential facility for emotionally and behaviorally disordered children. Ten of the subjects were from Rhode Island and 18 were from the State of Connecticut.

Youth are referred to this private, non-profit residential and day treatment facility based on a history of acting out in the community. The school system is unable to educate these difficult children in a public school setting. They are provided a wide range of psychiatric, social and educational services. The facility operates on an open campus in a rural setting. The average length of stay for the children is twenty-four months. A

significant proportion are wards of the state, and approximately 50% are from the state of Rhode Island and the other 50% are from the state of Connecticut.

To be included in this study, youth must have lived a minimum of six months at the residential facility. There were two reasons for the six month criterion: (1) children who suffer from attachment disorders often have symptoms of “superficial charm” in which they may go through a “honeymoon” period; and (2) six months is enough time for the child care workers to get to know the children (Randolph, 1997).

Procedure:

Fifty-six consent forms were sent to parents and/or guardians. Consent was provided by 28 out of 56 possible subjects (50%). After obtaining informed consent from the parents or guardians, and child assent (see appendix B), a two step procedure was initiated.

The first step involved a record review. Documentation of present age, number of placements, age at first separation from primary caretaker, other diagnoses, ethnic origin, IQ, and delinquency record (if any) was drawn from existing records. The researcher developed a demographic data form to record characteristics from subjects (See Appendix C).

The second step was obtaining ratings of children’s attachment status. Childcare workers completed the Randolph Attachment Disorder Questionnaire (RADQ), for the children they supervise. They were chosen instead of teachers or therapists because they have the most direct contact with the children. Their job responsibilities include supervision, behavior management and counseling. The child care counselors work in their dorms 40 hours per week.

The childcare workers completed the RADQ during unit meetings. The childcare workers were not informed of the purpose of the RADQ or study. Each childcare worker was given a questionnaire for each of the children residing in the dormitory they supervise. From all the questionnaires completed for each child, two questionnaires were randomly selected from one male and one female child care worker. The reason for this is that the RADQ author suggested that females are more “sensitive” in completing the questionnaire than males.

Instruments:

The Demographic Data form was designed by the experimenter to guide the collection of relevant information. It aided in obtaining data on age, sex, used in this study. A form was completed for each subject utilizing his or her files. (See Appendix C for a copy of this form).

The Randolph Attachment Disorder Questionnaire (RADQ), developed by Dr. Elizabeth Randolph at the Evergreen Center in Boulder, Colorado, was used. The RADQ was developed to provide a behaviorally specific, objectively scored, and easily interpreted guide to the diagnosis of attachment disorder (Randolph, 1997). The RADQ was designed to be used by psychotherapists and school personnel to assist in identifying and diagnosing attachment disorder in children between ages 5 and 18 years. It can be routinely used as a screening tool to identify whether or not the behavior problems of a child are consistent with the presence of attachment disorder. In addition, it can distinguish children with attachment disorder from those with conduct disorder and other

psychiatric disorders. A child's score on the RADQ can be used to estimate the severity of his attachment disorder, and may indicate whether the child experiences anxious, avoidant, or ambivalent type of attachment disorder. The RADQ is administered by having the adult who is most familiar with the child complete it. According to Dr. Randolph, if the child is living in a group or residential setting and has no primary parent, the staff member who has spent the greatest amount of time with the child should be the one to complete the questionnaire.

The RADQ was constructed by combining 19 items from the Symptom Checklist, which was developed by Evergreen Consultants to describe the symptoms that therapists had observed when treating children with attachment disorder. However, no research had ever been conducted to determine the reliability and validity of the Symptom Checklist. It was combined with specific behaviors common to attachment disordered children. The result was a 30-item questionnaire, which was researched using four groups of subjects. Item analysis of the RADQ found that 27 of the 30 items significantly distinguished among groups. The three items that did not distinguish between groups were dropped from the inventory, and three new items were added. In addition, four items that did not significantly distinguish between groups, but to a lesser degree than the other 23 items, were revised. Thus, the current edition of the RADQ contains 23 items that are identical to the original instrument, four items that were revised as a result of initial validity research and three items were changed as a result of initial validity research (Randolph, 1997). The 30-item Likert Scale has ratings of 5 (high) to 1 (rarely). The scoring system rates individuals in mild, moderate or severe categories of attachment disorder. The RADQ indicates the presence of attachment disorder if the score is above

65, and the rater's response to #30 is a 4 or a 5.

The norms were developed using three groups of children: 1) those who have histories of severe maltreatment and behavior problems consistent with the presence of attachment disorder; 2) those who have histories of severe maltreatment, but who do not have behavior problems consistent with the presence of attachment disorder; and 3) those who have behavior problems consistent with the presence of conduct or oppositional/defiant disorder and who have no history of early maltreatment (Randolph, 1997).

The reliability of the RADQ was established using test-retest and internal consistency procedures (Randolph, 1997). Test-retest reliability was done by having a sub-group of 40 parents of attachment disordered (RAD) and 30 parents of normal (NOR) children complete the RADQ on two occasions, each six weeks apart. This technique yielded correlation coefficients of .82 for the RAD group, and .85 for the NOR group. These coefficients are within acceptable range to establish test-retest reliability of the RADQ. Internal consistency was measured using the split-half technique, and yielded a correlation coefficient of .84 for the RAD group and .81 for the NOR group.

Validity for the RADQ was established using several techniques. Face validity is assumed because each of the items was based upon descriptions taken from the Symptoms Checklist and additional clinical information.

Construct validity studies determined that the total RADQ score does distinguish between behavior disordered children with no history of maltreatment (DBD), maltreated children who do not have behavior problems (NAB), and normal (NOR) children. Dr. Randolph used an item analysis and all of the RADQ items showed significantly different

scores between RAD and NAB children. The findings indicate that the RADQ distinguished between maltreated children with and without symptoms of attachment disorder, and that the attachment disordered children had experienced more extensive maltreatment than children in the NAB group had (Randolph, 1997). Item scores were also compared for the RAD and DBD groups. There were significant differences between the two groups on all the RADQ items. The finding indicate that the RADQ distinguishes between children whose behavior problems are consistent with the presence of attachment disorder, and those whose behavior problems meet the diagnostic criteria for either Conduct Disorder or Oppositional/Defiant Disorder, but who have no history of severe maltreatment in early life. This means that the RADQ has high construct validity (Randolph, 1997).

Construct validity was also established by examining the relationship between RADQ scores and scores on other inventories that assess the variety of problems in children. Total RADQ scores for the RAD group were compared with sub-scale scores for the Personality Inventory for Children (PIC) for children aged 6-11 years, and with the Personal Concerns (PC) sub-scales of the Millon Adolescent Personality Inventory (MAPI) for children aged 12-17 years using the Pearson Product-Moment Correlation (Randolph, 1997).

The only PIC scales that were significantly correlated with the RADQ are the delinquency (DLQ) and hyperactivity (HPR) scales, and the DLQ scale was more significantly related to the RADQ than was the HPR scale. These findings indicate that the RADQ measures some aspects of delinquent behavior. The PIC manual (Lachar, 1987) states that the DLQ scale measures poor self-esteem and undisciplined behaviors, while

the HPR scale measures behaviors that are diagnostic of attention deficit disorder. Because the RADQ was designed to assess aspects of child behavior that are not measured by other available assessment tools, the finding that only these two PIC scales are significantly correlated with the RADQ indicated that the RADQ does not overlap with the PIC, except in those areas which the RADQ is designed to measure. This finding indicates construct validity for the RADQ. The high frequency of behaviors consistent with conduct disorder and attention deficit hyperactivity disorder (often leading to misdiagnosis of attachment disordered children with one or both of these two disorders) seen in conduct disordered children are assessed by the RADQ, at least in terms of its similarity to the PIC (Randolph, 1997).

Correlation's Between RADQ and PIC Scores

<u>Scale (PIC) correlation</u>	
DEP	.02
DLQ	.48 *
WDL	.11
PSY	.15
HPR	.24 *
SSK	.05

*Significant Correlation

Manual for Randolph Attachment Disorder Questionnaire, Randolph 1997, p.
12

Results

Demographic Characteristics:

The demographic information was used to build a profile on this sample of children who have experienced multiple out-of-home placements. This information is summarized in Table 1. It is interesting to note that fifty-four percent of the subjects had delinquency records, and one hundred percent have a history of abuse and maltreatment. Another

fascinating finding was that sixty-eight percent of the parents were not married at the time of the subject's birth. Seventy-eight percent were Caucasian, ten percent Hispanic and eleven percent were African American.

The mean age at admission to their present placement was 12 years old. The current age of the subject's is fourteen. The mean average in number of placements is seven and the mean age of first out-of-home placement was 7.4. The mean average IQ was 87.79 which places subjects in low average range of intelligence. Youths residing at this residential facility had an average of four separate diagnoses (DSM-IV,1994).

Table 1.

Characteristics of Subjects (n=28)

CHARACTERISTICS	N	PERCENT of Sample	MEAN(SD)	
Sex				
Male	28	100	n/a	
Female	0	0		
Current Age				
10 -12	4	14	14.6	21.83
13 -14	12	42		
15- 16	9	32		
17- 18	3	10		
Number of Placements				
1-3	1	3	7.5	3.51
4-6	14	50		
7-9	7	25		
10-12	3	11		
13+	3	11		
Age at First Placement				
0-2	6	21	7.4	56.79
3-5	5	18		
6-10	8	29		
11-15	9	32		
Delinquency Record				
Yes	13	46		n/a
No		15		
		54		
Parents Marital Status at Birth				
Married	8	29	n/a	
Divorced	1	4		
Not married	19	68		
History of Abuse				
Yes	28	100	n/a	
No	0	0		
Number of Diagnosis				
1-2	10	36	3.8	1.87
3-4	7	25		
5-6	9	32		
7-8	2	16		

Table 1. continue

Characteristics	N	Percent of Sample	Mean	(SD)
Ethnicity:				
Caucasian (not Hispanic)	22	79	n/a	
African American	3	11		
Hispanic	3	11		
IQ				
66 – 75	5	18	87.8	13.19
76 – 85	8	29		
86 – 95	8	29		
96 – 105	4	14		
106 – 115	2	7		
116 – 125	1	4		

Preliminary Analysis: RADQ Ratings

A preliminary analysis was completed to empirically test the RADQ author’s assertion that male and female raters complete the RADQ differently. A t-test resulted in no significant differences between male and female ratings ($t = .95$, $df = 27$), $p > .05$). Because of this lack of difference, a mean based on a random selected male and female rater for each subject was used as the dependent measure in the primary analysis.

Primary Analysis:

The mean RADQ score for this sample was 52.6 with a range of (low) 14 to (high) 82. Table 2 shows the frequency of scores for each attachment category hypothesized by the developer of the RADQ.

Table 2.

RADQ SCORING and NUMBER OF PLACEMENTS

Disorder	Score	f	%	Average Out-of – Home
Placements				
No Disorder	< 50	11	39	6.9
Mild Disorganized	50 – 60	8	29	6.0
Moderate to Severe	> 65	9	32	9.6

The above table indicate that thirty-two percent of the subjects showed severe symptoms of attachment disorders. Their scores range from 65 to 83. Severely Disordered attached subjects had an average of 9.6 placements in their lifetime.

An analysis of variance (ANOVA) was applied to answer the question, is there a difference in the number of out-of-home placements for these three groups? A one-way ANOVA indicated no difference ($p < .05$) in the number of out-of-home placements for children in the 3 attachment categories hypothesized by Dr. Randolph, ($F = 2.82$, $df = 2$, $p < .08$).

Due to the limited number of subjects available, it was decided to divide the subjects into two subgroups – those scoring greater than 65 ($n=9$), falling into the severe category, and those scoring under 65 ($n=19$) falling into none or mild disorder categories. An independent samples t-test was conducted with the independent variable being attachment status (severe disorder vs. no/mild disorder) and the dependent variable being number of out-of-home placements. The results of this t-test indicated a significant difference between groups ($t = -2.40$, $df = 26$, $p < .02$). Subjects who scored in the severe attachment disorder range experienced more out-of-home placements ($M = 9.7$) than

subjects scoring in the mild or no disorder of RADQ ($M = 6.5$).

To answer the primary research question concerning the relationship between multiple out-of-home placements and attachment status, the independent sample's t-test conducted did signify that the more out-of-home placement a subject experienced, the higher the RADQ score.

Relationship of RADQ ratings and other variables

To gain more information concerning attachment status, the impact of several predictor variables was investigated using a regression analysis. The predictor variable's used were 1) age at first placement, 2) maltreatment history, and 3) number of out-of-home placements. These were chosen because past research and theory suggest they are important variables impacting attachment. The multiple R for these three predictors with attachment status was 0.240 with no variable serving as a significant predictor of attachment status. The findings indicated no significance between 1) age at first placement and RADQ score, abuse and RADQ score. Table 3 displays the relationship of the RADQ ratings and the demographic variables. As displayed, the coefficients ranged from no ($r = .03$) to low, but significant ($r = .44$) in the correlation between attachment score on RADQ and the amount of time in present placement. This significance may be related to several factors: 1) the residential facility is not treating their attachment symptoms; 2) the more seriously disturbed children, including those with significant attachment disorder, stay longer partly due to lack of alternative placements; and 3) the subject has been at facility long enough for child care worker's to know them more critically to better rate the subjects on the RADQ.

One of the most interesting findings indicates, as displayed in Table 3, that IQ has no significance to level of attachment disorder.

Table 3 Correlation of Demographic Variables with Attachment Scores

Demographic Variables	RADQMF	N = 28
1. Age at Admission	r = .03	p < .88
2. Current Age	r = .33	p < .08
3. Number of Placements	r = .23	p < .23
4. Age at First Placement	r = -.07	p < .74
5. Delinquency Record	r = .12	p < .54
6. Marital Status	r = .30	p < .12
7. History of Abuse	r = -.04	p < .86
9. IQ	r = -.10	p < .60
10. Time in Present Placement	r = .44	p < .02
11. Diagnosis	r = .35	p < .07

Discussion

Based on attachment theory and evidence in research, it was hypothesized that children who exhibit high scores on the RADQ (Randolph Attachment Disorder Questionnaire), will have experienced higher numbers of out-of home placements such as foster care, residential treatment facilities, and psychiatric hospitals. In particular, it was predicted that the number of out-of-home placements was related to the attachment status

of male adolescents living in a residential treatment facility.

In general, the results of this study partially support the hypothesis. Looking at the number of multiple out-of-home placements and RADQ score analyzed using a t-statistic, the higher the number in out-of-home placements, the higher the score on the RADQ. Although this is interesting, a conclusive assertion cannot be made. It is recognized that the relationship is correlational and it cannot be implied that multiple placements cause higher RADQ scores. This relationship cannot be causal because it could very well be a predisposition that causes attachment disorder not the number of out-of-home placements. There was no significant difference obtained when subjects were divided into the three subgroups suggested by Randolph. This lack of difference could be due to the small sample size or to the possible measurement properties of the RADQ.

A notable outcome of this study is the finding that males and females did not differ in their ratings of children. It was hypothesized by the RADQ author that female raters were preferable over males because Randolph states “as attachment disordered children have greater difficulty relating to adult women than adult men”. Randolph further indicates that research has shown that fathers routinely rate their children as having significantly fewer symptoms than do mothers. This finding runs counter to the RADQ authors assertions. The scoring of male and female raters did not follow this prediction.

Limitations:

As mentioned above, a concern of this study is the small sample. It is difficult to find relationships with an negligible number of subjects. Additionally, the sample was homogenous in that all the subjects came from a population of emotionally disordered boys from the same residential treatment facility. At the initiation of the research it was

understood that because the investigator was not testing the subjects directly, approval to do research could be expedited. However, because this is a protected population, it was extremely difficult to get approval. In addition, because the subjects are in an institution with many being wards of state, it was an endless battle to get consent from such a variety of diverse sources. Certainly, a larger more diverse sample would have added to the impact of results. There was not enough diversity among ethnic backgrounds. It would have been helpful to achieve a wider range of ages to use in the research. Indeed, much more knowledge may have been gained with a more diverse sample of subjects.

Implications:

Given the number of out-of-home placements of this sample, it is unlikely, that by the time such children reach adulthood that even long-term programs will be able to ameliorate their problems. It is recognized that a series of out-of-home placements may not be the sole cause of attachment disorder. However, there was a relationship between number of placements and RADQ score. The issue for this population is not how to prevent placement but, rather, how to prevent successive placements. It is hoped that this would better insure a safe passage through childhood and adolescents giving a half decent chance for adequate functioning, as a young adult.

There exist hundreds of studies about attachment in infancy and in adult attachment, and on the subject of attachment in general. However, little has been done in the area of attachment disorder, and virtually none in the effective treatment in this area of psychopathology. It is clear in the research that the behavior of children with attachment disorder often appears similar to and is often misdiagnosed as conduct disorder,

oppositional defiant disorder, and/or attention deficit-hyperactive disorder (Randolph, 1997). It is important to distinguish those children whose behavior problems indicate the presence of attachment disorder from those who have other diagnoses such as the ones mentioned above.

Treatment for attachment disorder is critical. The Attachment Center of Evergreen in Colorado has investigated the effect of attachment therapy has on reducing aggressive and delinquent behaviors in attachment disordered children (Goodwin, 1996).

Attachment therapy has evolved over the past 25 years and include four basic therapeutic techniques: 1) cognitive restructuring which is helping the child to recognize the cognitive errors in his/her thinking and to learn more healthy cognition's about him/herself and about others, 2) psychodrama which is taking the child through early life events that are acted out by others in the room so that he/she can find better solutions with dealing the trauma of those events and so have less an detachment (Goodwin, 1996).

Suggestions for Future Research:

Future research should look to include a greater number of subjects. It should include both males and females. It should also take a geographic cross-section of a large population of children living in out-of-home placements.

In conclusion, the results of this study, although not strong, do indicate that it is consistent with the attachment literature. There is agreement among the sciences that attachment is indeed ethnological and critical for development and later functioning. In addition, there is a philosophical and ethical issue of moving children from placement to placement. It is imperative that the study of this population looks at the issue of placing children in multiple settings, such as foster homes.

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APPENDIX A

Review of the Literature

Historical Overview of Attachment

Inspired by Spitz (1949), the many contributions of John Bowlby (1958, 1969, 1973, 1979, 1980, and 1994) served as the foundation for attachment theory. In 1958, Bowlby applied an attachment theory to an understanding of the child's relationship to his mother. In his survey of existing research, Bowlby reported two revolutionary, albeit simple findings: (a) the infant's need for his parents is analogous to his need for food and (b) significant separation from or loss of the primary caretaker results in psychological trauma to the child. The trauma's effect on the child may range from minor short-term emotional insecurities to major long-lasting aberrations in the ability to relate to other human beings.

Attachment theory grew out of the sciences of ethnology, developmental psychology, and psychoanalysis. Bowlby (1988) was the first to study attachment and is often referred to as the "father" of attachment theory. He combined his knowledge and experiences with Piaget's developmental psychology, Freud's psychoanalysis, Lorenz's work of imprinting goslings, and Harlow's research with primates, to develop a theory of attachment that has withstood the critics through the years and has come into its own as a reliable and empirically valid theory. Bowlby's model concludes that there is an innate need for social interaction in human infants that eventually becomes focused on a specific human figure, usually the mother. Today, Bowlby's thoughts are tremendously useful in the understanding and treatment of children with attachment difficulties.

The bulk of developmental research indicates that the human infant is seemingly biologically programmed at birth for social interaction and bonding (DeCasper & Fifer,

1980; Field, Cohen, Greenberg, & Woodson, 1982; Johnson, 1994; Lewcowicz & Turkewitz, 1980; Lichtenberg, 1983; Sagi & Hoffman, 1976; Sherrod, 1981; Simner, 1971; Stern, 1977, 1985; Tronick & Adamson; 1980).

During an earlier stage in the development of the human species, the closeness of a baby to its mother was necessary for physical survival. The formation of the attachment bond guaranteed that the baby would remain close to its mother and therefore safe. Attachment appears to be an evolutionary strategy for the survival and proliferation of the species (Barbaree, 1993; Bowlby, 1969, 1973, 1979, 1980; Calfee, 1992; Delaney, 1993).

The affectionate bond (attachment) when strong and healthy, however, can do much more than ensure the child's physical survival. "...it allows him to develop both trust in others and reliance on himself" writes Vera Fahlberg (1979, p.5). She further writes, "The bond that a child develops to the person who care for him in his early years is the foundation for his future relationships with others". Fahlberg also contends that attachment is the most critical thing that happens in infancy other than meeting the baby's physical needs. Lamb (1982) concurs. Other experts agree that the development of attachment is at the core of meeting basic social and personality needs such as (a) trust, (b) maintaining self-esteem, (c) developing a conscience, and (d) being affectionate and empathetic towards others (Barbaree, 1993; Bowlby, 1969, 1979; Cline, 1992; Frazier & Levine, 1983; Hazen & Shaver, 1990; Johnson, 1994; Lamb, 1982; McKelvey & Stevens, 1994; Verrier, 1991)

The Cycle of Bonding and Attachment

Robert Zaslow (1975) referred to the bonding cycle as an almost magical cycle that gives birth to one's soul. He used the word soul because it expresses unique, special

human qualities of thoughtful caring for others along with the internal belief in something beyond us—something that is far greater than ourselves. Other great minds have written of the result of this cycle in their own terms. Erickson wrote of the development of basic trust (1950). Psychoanalysts have spoken about the internalization of the good parent (Winnicott, David, & Shepherd, 1984). This essential cycle completes about every four hours as the infant is fed. At six months of age, the cycle has been completed hundreds of times and has served to lock our first association patterns. Although unconscious, these associations dictate many of our actions throughout our lives. At any step if things go wrong, lasting and severe psychopathology may result (Ainsworth, 1979; Bowlby, 1979; Craft, Granger, & Stephenson, 1964; Cloninger, 1978; Johnson, 1994). The importance of this cycle cannot be overemphasized (Barbaree et al., 1993; Belskey & Nezworski, 1988; Cline, 1970, 1979, 1992, 1995; Hazen & Shaver, 1990; McKelvey & Stevens, 1994; Verrier, 1991).

The bonding cycle has four stages (Cline, 1992; Magid & McKelvey, 1987; McKelvey & Stevens, 1994). They are:

Stage One: Need

Infants are born needing. By age two they have graduated to needing and wanting, but the first year they are a squirming bundle of needs. If these early needs are not met, the infant will die.

Stage Two: Rage Reaction

Infants express their needs in a rage reaction. It appears that feelings build to a swell of rage, as hunger pains grow intolerable. They may go through a series of feelings that range from helplessness, anger, and hopelessness, all of which together form rage (Cline,

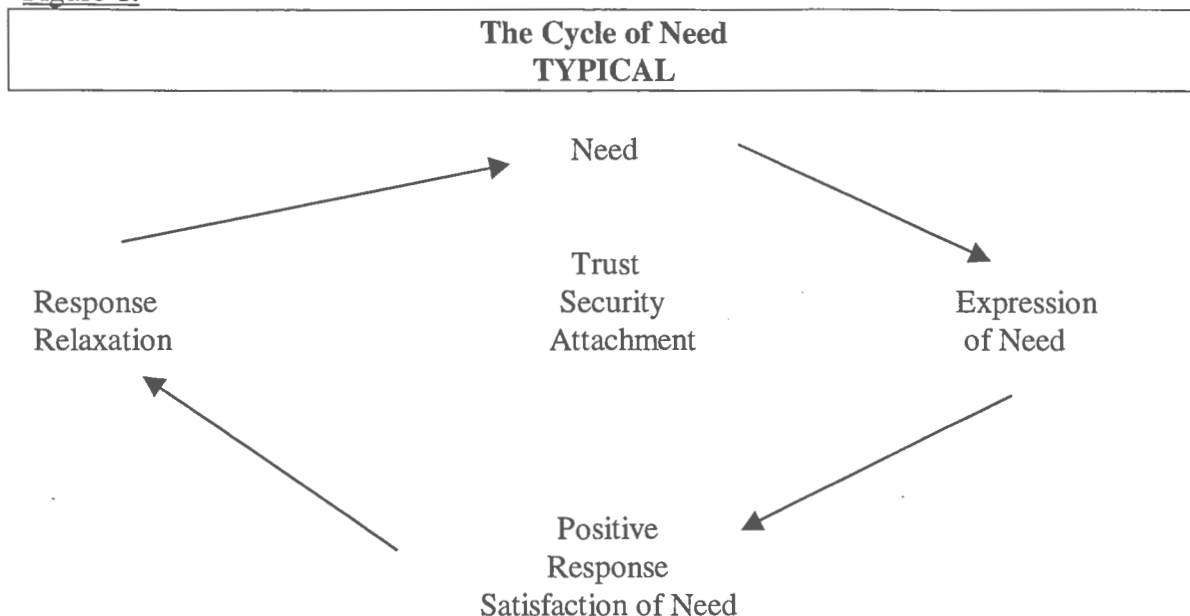
1992). The rage is expressed by loud agitated crying. Because they're needs are survival issues, the rage is oceanic and overpowering, and the infant screams louder and louder, kicks harder and harder, flails about with his arms, sometimes holds his breath, and turns red. Ideally, the caregiver relieves the baby's need before full rage builds by lifting the baby out of its crib and trying to satisfy its needs.

Stage Three: Gratification and Satisfaction

Adequate satisfaction of needs happens optimally in a normally responsive environment and, with a healthy organism At this point, moving from Stage Two (rage) to Stage Three (gratification) is the time when things may go wrong. The cycle often becomes broken at this point, and severe psychopathology is most likely to set in.

Figure One demonstrates how child antecedents and associations that occur in the first year of life are unconsciously carried on in adult life. In infancy, satisfaction of needs generally involves food. As noted in Figure One, while infants are being satisfied with food, they are also given other sensory inputs, which will be closely associated for a lifetime. These are (a) food, (b) labyrinthine stimulation (the labyrinth is that part of the inner ear associated with motion and position), (c) eye contact, (d) the human face and smile, (e) touch (Cline, 1992).

Figure 1.



Stage Four: Trust

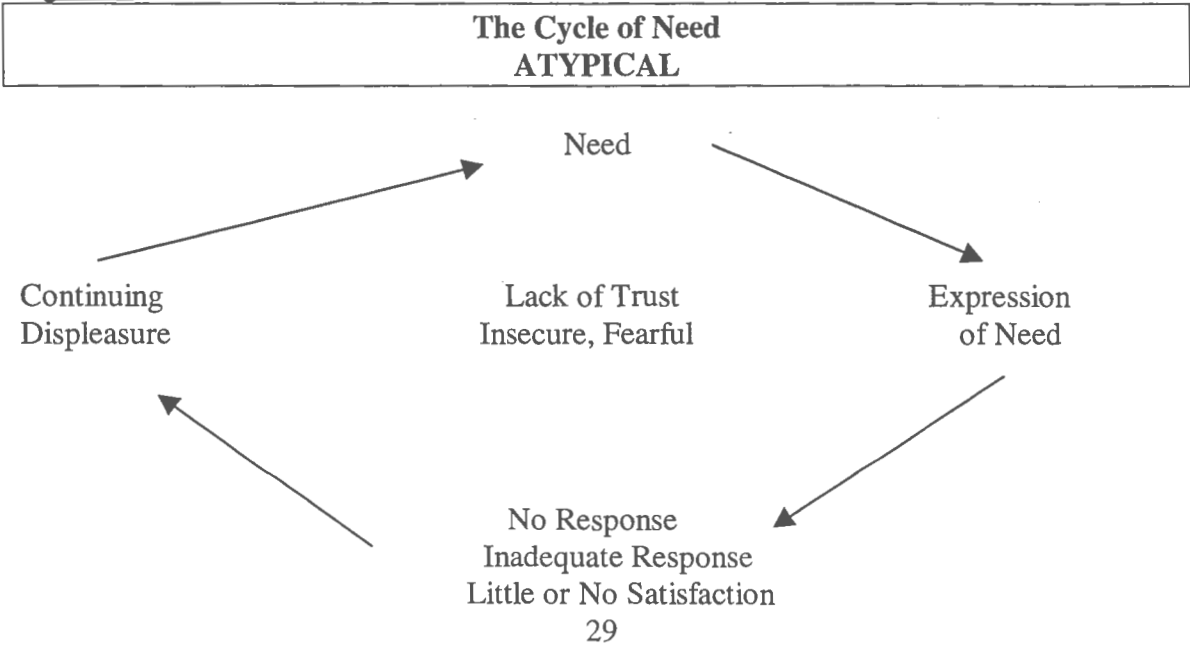
If the environment is reasonably and consistently giving and if infants are able to assimilate the environment satisfactorily, they are able to move on to stage Four, developing a sense of trust.

When Bonding Fails:

Normal attachment fails to take place with the bond in the first year is severely broken in any manner. When there is a lack of trust, proper attachment appears impossible. Both lack of attachment and lack of trust have far-reaching destructive influences on personality development, interpersonal relationships, and education (Cline, 1992). Bowlby (1979) stated that “prolonged or repeated disruptions of the mother-child bond during the first five years of life are known to be especially frequent in patients later diagnosed as having psychopathic or sociopath personalities” (p. 81).

Sometimes when the early environment does not meet children’s needs, they cannot develop basic trust. At other times, the environment is reasonably giving, but unfortunately, the child has a painful problem that an appropriately concerned mother cannot relieve. She may not even know about it. Also there are many nonphysical reasons for a break in the vital first year cycle: (a) postpartum depression, (b) parental breakup, (c) economic deprivation, (d) natural catastrophe, and so forth which tend to prevent the mother from being reasonably responsive, spontaneous, receptive, and gratifying to her needy helpless child. Some children are simply not wanted and therefore just tolerated, neglected, or even abused by the parents. Other children are given up to the system through abandonment, daycare, foster placement, or adoption. For whatever reason, disruption of attachment during the first year of life can affect the child in very destructive ways (Delaney, 1993) such as failure to develop basic trust. Basic trust seems to contain (a) trust of self, (b) trust of others, and (c) trust of humanity (Cline, 1995; Erickson, 1950).

Figure 2.



Mary Ainsworth (1989) and colleagues advanced Bowlby's work by developing an assessment, the Strange Situation, which documents infants' and mothers' reactions to separation and reunion. This research revealed three distinctive patterns of attachment: secure attachment, insecure-avoidant attachment, and insecure-resistant attachment. In secure attachment relationships, infants are highly sensitive to their mother's presence and keenly aware of her leaving the room. They become distressed but are easily comforted upon their mother's return and immediately seek proximity. Infants categorized as demonstrating insecure-avoidant attachment explore and play without concern for their mother's whereabouts and are not distressed by her absence. When the mother returns, the infant appears indifferent. In insecure-resistant attachment, infants are preoccupied with attachment. They do not have an interest in exploration and play. Mary Main and her colleagues further developed a fourth category of insecure attachment.

Disorganized attachment is associated when attachments are downright traumatic. This disorganized pattern is often associated with more severe forms of maltreatment, including physical, sexual and emotional abuse. In addition, neglect and abandonment are issues associated with disorganized attachment. In the Strange Situation, the behavior of infants exhibiting disorganized attachment lacks clear goals and is contradictory (Main & Solomon, 1990). The infant may alternate among proximity seeking, avoidance, and resistance behaviors. The infant is in a situation of intolerable conflict. This contradiction is the core experience in many traumatic experiences. The disorganized infant is in a dilemma, and there is no way to adapt successfully, which may result in attachment disorders.

The influence of early infant-caregiver relationships on later relationships has received some empirical support. Elicker, Englund, and Strouffe (1992) for example, found that infant attachment classification patterns were reliably associated with self-confidence and social skills at ten years of age. Children who were classified as securely attached as infants were more likely to be self-confident and exhibit adequate social skills at age ten as compared to children who were classified as resistant or avoidant as infants.

Appendix B

Consent Forms

CONSENT FORM FOR PARENT/GUARDIAN

**The University of Rhode Island
Department of Human Development and Family Studies
Kingston, RI 02881-0818**

Relationship Between Attachment and Out-of-Home Placements in Emotionally and Behaviorally Disordered Adolescents.

Consent for Release of Information

I have been asked to grant permission to Gail Curran, researcher at the University of Rhode Island, to allow information regarding said child to be collected for research purposes. The following summary will explain project in detail. If I have any questions, Gail Curran (949-0690) or Diane Horm-Wingerd (874-2150) the people responsible for this study, can be contacted.

Description of the project:

The study will investigate the characteristics of children receiving services at Harmony Hill School. The purpose is to look at the social and emotional development of these children.

What will be done:

- 1.) The researcher (Gail Curran) who is an employee at Harmony Hill School, will look at each child's file and record certain characteristics for each child; 2.) The researcher will ask child care workers to complete a questionnaire for each of the children they work with. The questionnaire contains questions about observed behaviors that the child care workers make while working with them. The information will be used by the URI researchers to investigate behavioral characteristics of the residents at Harmony Hill School.

Benefits of this study:

The purpose of this study is to investigate the behavioral characteristics of children living in a residential facility. The information collected will help the researcher determine the impact of behaviors in children with emotional and behavioral difficulties. This information will help us learn about these children and contribute to a greater knowledge of effective treatment.

Confidentiality:

This study is completely confidential. In no way will the children themselves be tested or asked to participate in any area of the study. The children's names and Harmony Hill School will be kept confidential.

Decision to not grant permission:

The decision to grant permission to the researcher in this study is up to me. I do not have to grant permission for information about child to be released.

I have read the consent to release information form. My role and rights in this study has been explained and I understand them. My signature on this form means I understand the information and I agree to grant the researcher permission to use information about child for the study.

The child's participation has been explained to me and all my questions have been answered.

_____ I allow information regarding my child to be used in this study.

Signature of Parent/Guardian

Signature of Researchers

Printed Name of Parent/Guardian

Printed names of researchers

Date

Date

CHILD ASSENT FORM

The University of Rhode Island
Department of Human Services and Family Studies
10 Lower College Rd
Kingston, RI 02881

**RELATIONSHIP BETWEEN ATTACHMENT AND OUT-OF-HOME
PLACEMENTS IN EMOTIONALLY AND BEHAVIORALLY DISORDERED
ADOLESCENTS**

ASSENT FORM FOR RESEARCH

**I HAVE READ (OR HAVE READ TO ME) THE REQUIREMENTS OF THE
RESEARCH PROJECT OF GAIL CURRAN. I HAVE HAD A CHANCE TO
TALK ABOUT THIS RESEARCH WITH THE RESEARCHER (GAIL CURRAN)
AND ALL MY QUESTIONS HAVE BEEN ANSWERED. MY SIGNATURE ON
THIS FORM MEANS THAT THE CHILDCARE WORKERS CAN FILL OUT A
QUESTIONNAIRE ABOUT MY BEHAVIOR. I UNDERSTAND THAT IF I DO
NOT WANT MY COUNSELOR TO FILL OUT QUESTIONNAIRE ABOUT MY
BEHAVIOR, I DO NOT HAVE TO SIGN THIS FORM.**

Signature of Participant/child

Signatures of Researchers

Printed Name

Printed Names of Researchers

Date

Date

The University of Rhode Island
Department of Human Development
Kingston, RI 02881-0818

Relationship Between Attachment and Out-of-Home Placements in Emotionally and
Behaviorally Disordered Adolescents

Child Care Worker Consent Form For Research

I have been asked to take part in the research project described below. The following summary will explain the project in detail. If I have questions, Gail Curran (949-0690) or Diane Horm-Wingerd (874-2150) the people responsible for this study, can be contacted.

Description of Project:

I have been asked to take part in a study that will investigate the characteristics of children receiving services at Harmony Hill School. The purpose of this study is to look at the social and emotional development of these children.

What will be done:

If I decide to take part of this study, here is what will happen:

During Department or Unit meetings, I will be asked to complete a questionnaire for each of the children I work with. Each questionnaire will take approximately five minutes per youth. In all, it will take me approximately one hour to fill out the questionnaire. This will be done during work time. The information will be used by the URI researchers to investigate the behavioral characteristics of the residents living at Harmony Hill School.

Please note on the questionnaires "My child" refers to the children that you are supervising.

Risks or discomforts:

Because this study involves only paper-and-pencil questionnaires, no significant risks or discomforts are anticipated.

Benefits of this study:

The purpose of this research is to investigate the behavioral characteristics of the residents at Harmony Hill School. Although there will be no direct benefit to me for taking part of this study, the information I provide will help the researchers determine the impact of behaviors in children with emotional and behavioral difficulties living in a residential facility. The information I provide in this study will help us learn about these children and contribute to a greater knowledge of effective treatment for them.

Confidentiality:

My part in this study is confidential. None of the information collected will identify me by name. Instead of using names, all records will use numbers to identify subjects. Any written summaries will report group data, not individual responses.

Decision to quit at any time:

The decision whether or not to take part in this study is up to me. I do not have to participate. If I decide to take part in this study, I may quit at any time. Whatever I decide to do, I will in no way be penalized in my job performance or status at Harmony Hill School.

Rights and Complaints:

If I am not satisfied with the way this study was performed, I may discuss my complaints with Gail Curran or Diane Horm-Wingerd (874-2150), anonymously, if I choose. In addition, I may contact the office of Vice-Provost for Research, 70 Lower College Road, University of Rhode Island, Kingston, RI at (401) 874-4238.

I have read the consent form. My role and rights in this study has been explained. My signature on this form means that I understand the information and I agree to participate in this study.

Signature of Participant

Signatures of Researchers

Printed Name

Gail Curran

Diane Horm-Wingerd

Printed Names

Date

Date

Appendix C

Instruments

1. Demographic Data Form
2. RADQ

APPENDIX C

Demographic Data Form Coding Sheet for Client Demographics

_____ Code number for child

_____ Age of admission into program

_____ Present age

_____ Number of placements

_____ Age at first placement

_____ Delinquency record NO = 1 YES = 3

_____ Marital Status of Parent at time of birth

_____ Mother: single = 2 divorced = 1 married = 0

_____ Father: single = 2 divorced = 1 married = 0

_____ History of abuse No = 0 Yes = 1

_____ Ethnic Origin

_____ IQ

_____ Diagnosis

_____ Amount of time in present placement

_____ RADQ score

RADQ

Child's Name _____ Age _____ Today's Date _____

DIRECTIONS: Read each of the statements below and circle the number that **BEST** describes how often your child shows that trait. If he/she usually shows it (90% or more of the time), circle the 5. If he/she often shows it (75% of the time), circle the 4. If it is present about half of the time, circle the 3. If it is occasionally present (about 25% of the time), circle the 2. If it is rarely or never present (less than 10% of the time), circle the 1. Please make sure that you mark **ONE** and only **ONE** answer to each item, and that you mark an answer to **EACH** item. Do not mark between the numbers. Also, be sure to mark your answers in accordance with your child's behavior over the past 1-2 years, not just in the last 3-6 months, unless specifically asked to do otherwise for research purposes.

	(5) usually	(4) often	(3) sometimes	(2) occasionally	(1) rarely
1) My child acts cute or charms others to get them to do what he/she wants.	5	4	3	2	1
2) My child has trouble making eye contact when adults want him/her to.	5	4	3	2	1
3) My child is overly friendly with strangers.	5	4	3	2	1
4) My child pushes me away or becomes stiff when I try to hug him/her, unless he/she wants something from me.	5	4	3	2	1
5) My child argues for long periods of time, often about ridiculous things.	5	4	3	2	1
6) My child has a tremendous need to have control over everything, becoming very upset if things don't go his/her way.	5	4	3	2	1
7) My child acts amazingly innocent, or pretends that things aren't that bad when he/she is caught doing something wrong.	5	4	3	2	1
8) My child does very dangerous things, ignoring how he/she may be hurt while doing them.	5	4	3	2	1
9) My child deliberately breaks or ruins things.	5	4	3	2	1
10) My child doesn't seem to feel age-appropriate guilt for his/her actions.	5	4	3	2	1
11) My child teases, hurts, or is cruel to other children.	5	4	3	2	1
12) My child seems unable to stop him/herself from doing things on impulse.	5	4	3	2	1
13) My child steals, or shows up with things that belong to others with unusual or suspicious reasons for how he/she got them.	5	4	3	2	1
14) My child demands things, instead of asking for them.	5	4	3	2	1

	(5) usually	(4) often	(3) sometimes	(2) occasionally	(1) rarely
15) My child doesn't seem to learn from his/her mistakes and misbehavior (no matter what the consequence, the child continues the behavior).	5	4	3	2	1
16) My child tries to get sympathy from others by telling them that I abuse and/or neglect him/her.	5	4	3	2	1
17) My child "shakes off" pain when he/she is hurt, refusing to let anyone comfort him/her.	5	4	3	2	1
18) My child likes to sneak things without permission, even though he/she could have had them if he/she had asked.	5	4	3	2	1
19) My child lies, often about obvious or ridiculous things, or when it would have been easier to tell the truth.	5	4	3	2	1
20) My child is very bossy with other children and adults.	5	4	3	2	1
21) My child hoards or sneaks food, or has other unusual eating habits (eats paper, raw flour, package mixes, baker's chocolate, etc.).	5	4	3	2	1
22) My child can't keep friends for more than a week.	5	4	3	2	1
23) My child throws temper tantrums (screaming fits) that last for hours.	5	4	3	2	1
24) My child chatters non-stop, asks repeated questions about things that make no sense, mutters, or has other oddities in his/her speech.	5	4	3	2	1
25) My child is accident-prone (gets hurt a lot), or complains a lot about every little ache and pain (needs constant band-aids).	5	4	3	2	1
26) My child teases, hurts, or is cruel to animals.	5	4	3	2	1
27) My child doesn't do as well in school as he/she could with even a little more effort.	5	4	3	2	1
28) My child has set fires, or is preoccupied with fire.	5	4	3	2	1
29) My child prefers to watch violent cartoons and/or TV shows or horror movies (regardless of whether or not you allow him/her to do this).	5	4	3	2	1
30) My child was abused/neglected during the first year of his/her life, or had several changes of his/her primary caretaker.	5	4	3	2	1

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